Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
TWELVE OAKS MEDICAL CENTER
HOLLAWAY & GUMBERT
3700 KIRBY DRIVE SUITE 1288
HOUSTON TX 77098

Carrier's Austin Representative Box
#29

MFDR Date Received
OCTOBER 4, 2005

Respondent Name
CAMDEN FIRE INSURANCE ASSOC

MFDR Tracking Number
M4-06-1263-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated October 3, 2005: "Please be advised our law firm has been retained by the Requestor, Twelve Oaks Medical Center."

Requestor's Supplemental Position Summary Dated October 17, 2005: "This letter is to confirm that our client, Twelve Oaks Medical Center, hereby withdraws the service shown on the attached UB-92 as revenue code '990' "PERSONAL ITEMS' with charge of $23.50, which the carrier denied for 'U' – 'UNNECESSARY MEDICAL (W/O PEER REVIEW).' It is our understanding that withdrawal of this service will preclude submission for IRO review, and will allow this dispute to go forward for review by medical dispute resolution."

Requestor's Supplemental Position Summary Dated November 3, 2005: "It Is our position that reimbursement was improperly determined pursuant to the acute care inpatient hospital fee guidelines of the Division…Under Rule 134.401(c)(6) of the acute care inpatient hospital fee guidelines of the Division, this claim would be reimbursed at the stop-loss rate of 75% as the total audited charges exceed the minimum stop-loss threshold of $40,000.00 resulting in a reimbursement of $48,777.02. Based on the wording of the rules of the Division, the carrier is liable for an additional sum owed…in the amount of **$41,055.47**."

Amount in Dispute: $41,055.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated October 19, 2005: "It is the position of the Carrier that no additional payment is due for the date of service made the basis of this dispute. All charges were paid in the correct amount and with the appropriate exception codes listed on the TWCC 62/EOB…The requestor has not provided documentation that the services provided were 'unusually costly' or 'unusually extensive'. No additional reimbursement is indicated."

Response Submitted by: Dean G. Pappas & Associates on behalf of OneBeacon Insurance Company

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
October 4, 2004 through October 7, 2004	Inpatient Hospital Services	$41,055.47	$159.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- 480 – REIMBURSEMENT BASED ON THE ACUTE CARE INPATIENT HOSPITAL FEE GUIDELINE PER DIEM RATE ALLOWANCES.
- 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
- 353 – THIS CHARGE WAS REVIEWED PER THE ATTACHED INVOICE.
- *NOTE* – PAYMENT BASED ON THE TWCC PER DIEM ALLOWANCE FOR INPATIENT HOSPITAL STAY, AS DOCUMENTATION DOES NOT INDICATE ANY SERVICES THAT ARE UNUSALLY EXTENSIVE OR COSTLY.
- F – FEE SCHEDULE MAR REDUCTION
- G – UNBUNDLING
- N – REDUCED TO FAIR AND REASONABLE
- Preferred Provider Organization: ROCKPORT HEALTHCARE GRP
- 219 – THIS PROCEDURE, SUPPLY, SERVICE OR REPORT DOES NOT NORMALLY WARRANT A CHARGE.
- 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.

Issues

1. Did the audited charges exceed $40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28

Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A)(v) of that same section states "Audited charges are those charges which remain after a bill review by the insurance carrier has been performed." Review of the explanation of benefits issued by the carrier finds that the carrier deducted $23.50 for personal convenience charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $65,012.52 ($65,036.02 - $23.50). The division concludes that the total audited charges exceed $40,000.

2. The requestor in its position statement presumes that it is entitled to the stop loss method of payment because the audited charges exceed $40,000. As noted above, the Third Court of Appeals in its November 13, 2008 opinion rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved…unusually extensive services." The requestor failed to demonstrate that the particulars of the admission in dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 Texas Administrative Code §134.401(c)(6).

3. In regards to whether the services were unusually costly, the requestor presumes that because the bill exceeds $40,000, the stop loss method of payment should apply. The Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must ***demonstrate*** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to demonstrate that the particulars of the admission in dispute constitutes unusually costly services; therefore, the division finds that the requestor failed to meet 28 Texas Administrative Code §134.401(c)(6).

4. 28 Texas Administrative Code §134.401(b)(2)(A) titled General Information states, in pertinent part, that "The basic reimbursement for acute care hospital inpatient services rendered shall be the lesser of:
   (i) a rate for workers' compensation cases pre-negotiated between the carrier and the hospital;
   (ii) the hospital's usual and customary charges; and
   (iii) reimbursement as set out in section (c) of this section for that admission

   In regards to a pre-negotiated rate, the services in dispute were reduced in part with the explanation "Preferred Provider Organization: ROCKPORT HEALTHCARE GRP." No documentation was provided to support that a reimbursement rate was negotiated between the workers' compensation insurance carrier Camden Fire Insurance Assoc. and Twelve Oaks Medical Center prior to the services being rendered; therefore 28 Texas Administrative Code §134.401(b)(2)(A)(i) does not apply.

   In regards to the hospital's usual and customary charges in this case, review of the medical bill finds that the health care provider's usual and customary charges equal $65,036.02.

   In regards to reimbursement set out in (c), the division determined that the requestor failed to support that the services in dispute are eligible for the stop-loss method of reimbursement; therefore 28 Texas Administrative Code §134.401(c)(1), titled Standard Per Diem Amount, and §134.401(c)(4), titled Additional Reimbursements, apply. The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
   - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission." The length of stay was three days. The surgical per diem rate of $1,118.00 multiplied by the length of stay of three days results in an allowable amount of $3,354.00.

   - 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bill finds that the following items were billed under revenue code 278 and are therefore eligible for separate payment under §134.401(c)(4)(A):

Description of Implant per Itemized Statement	Quantity	Cost Invoice	Cost + 10%
Inner Set Screw	3	$135.00	$445.50
MMSI 6X40 Poly	1	$850.50	$935.55
SZ 10 Crosslink	1	$1,100.00	$1,210.00
SZ 9 Crosslink	1	$1,100.00	$1,210.00
4-10mm .30cc	1	$525.00	$577.50
95mm Prbnt Rod	1	$135.00	$148.50
Total			$4,527.05

The total reimbursement set out in the applicable portions of (c) results in $3,354.00 + $4,527.05, for a total of $7,881.05.

Reimbursement for the services in dispute is therefore determined by the lesser of:

§134.401(b)(2)(A)	Finding
(i)	Not Applicable
(ii)	$65,036.02
(iii)	$7,881.05

The division concludes that application of the standard per diem amount and the additional reimbursements under §134.401(c)(4) represents the lesser of the three considerations. The respondent issued payment in the amount of $7,721.55. Based upon the documentation submitted, additional reimbursement of $159.50 can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in additional reimbursement .

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $159.50 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/19/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.